

# The Business of Caring



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## Digging Up Gold from Service Line Data

What will you get when an experienced nurse executive teams up with a skilled financial executive to analyze data about their hospital's cardiac service line?

Given enough time and analytical savvy, the nurse-finance team will undoubtedly discover some opportunities—including ways to reduce costs and increase profits. For example, after studying data on cardiac volumes and profits, the two experts might identify a potential financial benefit in opening another cardiac cath lab. Or they might spot opportunities to reduce supply costs or improve patient throughput.

Maryann Cone, RN, MS, CNO and vice president of patient care services at Sharp Grossmont Hospital in San Diego, is a key contributor to her hospital's service line analysis. Cone and her CFO cohort, Kari Cornicelli, have used service line analyses to support decisions worth millions of dollars, from deciding how to allocate space for increasingly common procedures to identifying specific services that warrant heavier marketing support.

### **Form a Clinical-Finance Team**

Skilled in mining data and developing reports, financial executives need a clinical

perspective to validate the data or, in many cases, to suggest additional clinical data analysis that can shed new light on a situation. "You've got to have the clinician that's going to ask the 'what if' questions, or say 'this doesn't look right,'" said Cornicelli, CPA, FHFMA, CFO and vice president at Sharp Grossmont. "Clinicians can help validate the data and assist in understanding it, and they can be astute in asking for additional data that will help us further clarify the findings."

How often should service line performance be reviewed? At least annually, advise Cone and Cornicelli. "It certainly needs to be done when you're doing strategic planning because you're going to use the data to make decisions on where you want to grow business or reduce services," Cornicelli said. "And it needs to be done episodically if you've identified a problem or an issue and you want to validate your concerns."

Cone and Cornicelli analyze service line data on a quarterly basis. Cornicelli and her financial team pull the data and sort it—for example, by payer or physician—to develop various reports. Cone often suggests the reports that are needed.

### INSIDE THIS ISSUE

- How Are You Making Your Hospital a More Attractive Place to Work for Older Nurses?** 4
- Where Does the Money Go? Budgeting Scenarios for Front-Line Clinicians** 10
- Business School for Nurses** 12
- Ask a Nurse Leader** 13
- Finance-to-Nurse Interpreter** 13
- Career Opportunities** 14

### COMING IN MARCH

- Calculating ROI**
- Getting your hands on financial data**
- Improving emergency department throughput**

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“If we’re evaluating the data by payer, we might do an additional drill-down to look at reimbursement and into the contract issues,” Cornicelli says.

**☑ Analyze Service Line Profitability**

A good first step when analyzing service lines is to investigate where a hospital makes its profit: Identify the annual number of cases and total profit generated by cardiology, orthopedics, and every other service line the hospital offers.

At Sharp Grossmont, cardiac cases only account for 15 percent of hospital volume, compared to 33 percent from general-medical cases. Yet cardiac cases are the top profit contributors. While that finding would not surprise any healthcare executive, having numbers to attach to a common perception helps decision makers know where to focus attention.

**☑ Dig Deeper Into Each Service Line**

Use diagnostic-related group codes to organize inpatient cases into groups for analysis. For example, cardiac cases could be separated into the service line’s four major components: medical cardiology, electrophysiology, cardiac surgery, and interventional cardiology. Although the DRG groupings might differ slightly from one hospital to another, it’s good to estab-

**A good first step when analyzing service lines is to investigate where a hospital makes its profit: Identify the annual number of cases and total profit generated by cardiology, orthopedics, and every other service line the hospital offers.**

lish categories so you can track trends over time.

For each group you establish, look at two important numbers: total profits and average profit-per-inpatient case.

At Sharp Grossmont, cardiac surgery generates the largest profit per case. However, interventional cardiology, though less profitable on a per-case basis, generates nearly twice the overall profit for the hospital. That’s where a nurse leader’s insight—that an increasing volume of interventional cardiac procedures is driving down the number of cardiac surgeries—comes in handy. That trend, combined with the profitability analysis, can help when making decisions about equipment investments, space allocations, and marketing messages.

*continued on page 9* →

**Compare Profit and Volumes Across Physicians**

**Sharp Grossmont Hospital Cardiac Service Line**

**Physician Volume and Profitability Analysis\***

	Volume (Percent of Total Procedures)	Profitability
Physician A	5.7%	\$315,515
Physician B	5.4%	\$363,923
Physician C	4.8%	\$27,995
Physician D	4.7%	\$124,909
Physician E	4.4%	\$168,679
Physician F	4.4%	\$388,571

\* Data, which is annualized for 2006, reflects all payers. Physicians are attending MDs.

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**An analysis of physician performance can identify physicians whose practice patterns reduce a hospital’s profitability.**

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# How Are You Making Your Hospital a More Attractive Place to Work for Older Nurses?

*Experienced nurses ages 45 and older make up nearly one-third of today's healthcare workforce, according to a recent Robert Wood Johnson Report (see sidebar on page 8). Retaining these older nurses for as long as possible is seen as a key strategy in curtailing the nursing shortage. But it's not just about filling nursing shifts. It's also about avoiding a knowledge drain. Patients and younger nurses can only benefit from the wisdom and knowledge older clinicians bring to work every day.*

*So, how can you keep the older nurses on the job—and attract more to your organization? We asked nurse leaders at four hospitals—all of which have been recognized by AARP as some of the best employers around for older people—to discuss some of their multifaceted strategies for keeping older nurses happy and healthy on the job.*

## Case Study 1 Nurses Name Their Start Times

Hospitals that offer flexible scheduling to nurses often split shifts or use 8- or 10-hour shifts. Oakwood Healthcare, in Dearborn, Mich., tries to differentiate itself in the market by offering almost any start time possible, assuming that the manager is able to juggle staffing to fill the 24-hour period. More than half of the nursing schedules at Oakwood's four acute care hospitals follow this flexible model.

"A lot of consultants might frown at what we're doing, but it has been a real recruitment and retention advantage for us," said Barbara Medvec, RN, MSN, MSA, senior vice president and CNO. "It is one of the strongest features we have for experienced nurses who want to continue to practice but

can't fit their schedules to a 10- or 12-hour shift."

Medvec credits flexible scheduling with helping to cut turnover in half—from 18 percent in 2001 to about 9 percent in 2006. "Without flexible scheduling, Oakwood wouldn't be able to attract and retain the quality of employees we have today," said Medvec. "Also, with this option, there has been no marked increase in overtime. In fact, without flexible scheduling, there would be an increase in both the amount of overtime hours and agency use."

Flexible scheduling also benefits patient care: The hospital can staff to peak volumes, so there's always the right amount of coverage.

### Older Nurses Like Flexibility

Almost half of the RNs at Oakwood are ages

45 and older. "In our experience, flexible scheduling is attractive for older RNs for many reasons, particularly because nurses have the ability to maintain activity within their units while enhancing and reinforcing on-the-job skills. In addition, flexible schedules allow nurses extra support in their personal lives when it comes to family responsibilities, such as providing child-care to grandchildren."

While some may view Oakland's flexible scheduling program as an administrative nightmare, it's been very popular with nurses. "What it requires is diligence by the management team to pair schedules appropriately so that they can get full coverage for each shift," said Medvec. If a nurse works from 2 p.m. to 9 p.m., the manager needs to find a second nurse to work from 9 p.m. to 2 a.m. Each day is a puzzle that needs to be completed.

### Start with a Needs Assessment

Some form of flexible scheduling has been in place at Oakwood for the last 20 years. To put the new program in place, Oakwood leaders did a lot of upfront research:

- > Administrators met with several hundred Oakwood RNs to determine why they stay and what they needed to continue within the Oakwood organization. In addition, all 1,500 RNs were interviewed over a nine-month period to identify opportunities. Flex scheduling was in the top five areas for consideration.
- > Staff interviewed more than 100 of the RNs who had left the organization over a 24-month period. All RNs were invited to an open house to meet with Medvec as well. All of this feedback pointed to the need for flexible scheduling, as well as options for contingency scheduling.
- > The hospital reviewed evidence-based best practices for recruitment, retention, and satisfaction.

Through its redesign of nurse recruitment to improve throughput, Oakwood's nurse

*continued on page 6* →

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leaders also built opportunities for various unit schedule models. This included redevelopment of nursing grids and schedules.

### Centralized Registry Makes it Work

As a complement to its flexible scheduling, Oakwood has developed a centralized registry, which consolidates all of the contingent nursing staff—those who have more than two years of job experience but aren't receiving benefits—into a systemwide pool.

"We market it as our own internal agency," said Medvec. Working in this pool is a great option for older nurses who want to work less and might have otherwise left the organization to work at an outside agency.

Medvec sees it as a win-win situation. "They achieve the hours they want, and we're able to rely less on outside agencies." Since the registry was put in place, Oakwood has saved approximately \$1.2 million.

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Barbara Medvec, RN, MSN, MSA, is senior vice president and CNO at Oakwood Healthcare, Inc., in Dearborn, Mich. (medvecb@oakwood.org).

## Case Study 2

### Lifting Safety Protects Older Backs

In 2006, Texas became the first state in the country requiring hospitals to put better patient lifting programs into place. The law requires hospitals to restrict manual lifting of patients except when absolutely necessary.

Research shows that repeated patient lifting causes cumulative stress and strain on a nurse's body. No-lift policies are designed to help nurses avoid injuries—and they could help hospitals retain nurses. The American Nurses Association says that 12 percent of nurses leave the profession because of back pain.

At the M. D. Anderson Cancer Center, administrators believe that a "no-lift" policy alone is not enough to fully address the

issue of occupational injuries. So the nursing team is working with the organization's employee health and wellness department to develop a program to minimize the potential for workplace injuries related to moving patients.

### Benefits Nurses of All Ages

"Nursing in hospitals has historically been a physically demanding—often punishing—professional occupation," said Barbara Summers, RN, MSN, PhD, vice president and CNO at The University of Texas M. D. Anderson Cancer Center in Houston. "In contrast, the most valuable contributions of registered professional nurses are those associated with critical thinking, patient assessment and evaluation skills, exercise of clinical judgment, teaching, and counseling of patients and families."

"The initial impetus for this [M. D. Anderson's] program development was recognition of the aging demographic profile of our clinical nurses," said Summers. The average age of nurses at M. D. Anderson is 46 years old.

"What we have subsequently come to understand is that workplace ergonomic and safety improvements are good for all nurses. These improvements prevent injuries to chronically younger nurses and also reduce the physical burden of care for chronologically older nurses."

### Equipment Costs Redeemed in Four Years

Hospitals around the country are looking at a variety of patient lifting equipment, including:

- > Overhead track-mounted patient lifters, which uses sling lifts that are attached to the ceiling

- > Lateral transfer devices, which move a patient from bed to stretcher.
- > Sliding boards and mattress pads, which reduce friction and make it easier for staff to move patients from bed to chair or chair to car
- > Beds that transform into chairs, eliminating the need for patient transfer

The Department of Labor suggests that hospitals can save about \$27,000 every time they avoid a severe musculoskeletal disorder. In addition, the Department of Veterans Affairs conducted an 18-month study after the introduction of a lifting program at a Florida VHA system. A cost-benefit analysis showed net benefits from decreased workers' compensation claims was \$200,000 a year. The payback period of the initial investment in patient handling equipment was about four years.

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Barbara Summers, RN, MSN, PhD, is vice president and chief nursing officer at University of Texas M. D. Anderson Cancer Center in Houston (bsummers@mdanderson.org). Washington State's safe patient handling web site also has a lot of useful information about patient lifting programs. Visit [www.washingtonsafepatienthandling.org/home.html](http://www.washingtonsafepatienthandling.org/home.html).

## Case Study 3

### Full-Time Benefits for Part-Time Work

Scottsdale Healthcare in Arizona offers a seasonal leave program that's popular with nurses and other employees who wish to phase into retirement in a year or two. In the program, employees at both Scottsdale's campuses can work full- or part-time for six months of the year and receive full medical, dental, life, and disability benefits for the next six months (while taking a full-time leave).

**"Flexible scheduling has been a real recruitment and retention advantage for us. It is one of the strongest features we have for experienced nurses who want to continue to practice but can't fit their schedules to a 10- or 12- hour shift."**

“A nurse can work just two 12-hour shifts a week for six months and receive full benefits for a year,” said Peggy Reiley, PhD, chief clinical officer.

Seasonal staffing models that offer full benefits to employees can be expensive. But Reiley said the program is well worth the effort and investment. “The ROI is we retain an employee and do not have to orient a new one. Studies have shown that orientation costs are as high as \$50,000 to \$80,000, depending on the specialty,” she said.

Last year, 21 nurses took advantage of the program during the summer, when the organization’s census tends to be lighter.

Seasonal staffing models require more work for nurse managers to fill shifts. To fill the gaps at Scottsdale, nurse managers relied upon on-call staff. In addition, to limit the potential for problems, some units set or limit the number of staff that can be on seasonal leave at any one time.

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Peggy Reiley, PhD, is chief clinical officer at Scottsdale Healthcare in Scottsdale, Ariz. (preiley@shc.org).

## Case Study 4 Getting RNs Back to the Bedside

Experienced nurses want more time—time

### Identifying New Roles for Older Nurses

Scottsdale Healthcare in Arizona keeps older nurses happy by offering them career counseling—and helping them find positions in the organization that meet their needs for fewer hours, flexible schedules, or support roles. For example, many senior nurses flock to fill the roles of admission nurses at both campuses. In this capacity, older nurses have an opportunity to interact with patients and use their clinical skills without the heavy lifting or physical labor of a unit position.

Other roles for older nurses include case management, documentation, and heading up quality reviews. One nurse in her seventies moved to the role of unit secretary so she could stay engaged in work without the demands of a nursing job.

“We really want nurses to come to us and say, ‘I don’t know if I can work in the OR or on the unit for the next 10 years, but can you help me find out what else I can do here?’” said Peggy Reiley, PhD, chief clinical officer.

## The Department of Veterans Affairs conducted an 18-month study after the introduction of a lifting program at a Florida VHA system. A cost-benefit analysis showed net benefits from decreased workers’ compensation claims was \$200,000 a year. The payback period of the initial investment in patient handling equipment was about four years.

to care for patients, as well as time for their personal lives. Innovative programs at Seton Healthcare Network in Austin, Texas help older nurses do both.

### More Time at the Bedside

At many hospitals around the country, nurses are so bogged down by poor work processes that they only spend 30 percent of their time at the bedside. This can be especially frustrating for experienced nurses.

But at Seton Northwest Hospital, nurses on some units are spending up to 60 percent of their time on direct patient care, said Joyce Batcheller, RN, MSN, CNAA, network chief nursing officer. Through its participation in Robert Wood Johnson’s *Transforming Care at the Bedside* initiative, the hospital has been able to tap into nurse ideas for eliminating waste.

Some of the improvements include using a “traffic light” system in which nurses update their workload status every hour on

a bulletin board. Nurses use red, yellow, and green tabs to show if they need assistance or if they can take a new admission. “This has created greater teamwork, and patient flow has improved,” said Batcheller.

Another timesaver implemented was interdisciplinary rounding, during which nurses, physicians, and therapists participate in patient rounds together. Batcheller said this has proved to be a timesaver for nurses because it reduces the number of calls to physicians for questions and clarifications.

Other small timesavers that nurses implemented include:

- > An extra drug dispensing cabinet on the unit saves nurses’ time when retrieving medications.
- > Doses of morphine and Dilaudid® were limited to their most frequently used dosages, eliminating the need to find a second nurse for unused portions.
- > Volunteers are now used to help copy charts.

In November 2006, Seton began spreading these processes throughout its network.

“All of this adds up to a lot of time being saved and less hassles for the nurses,” said Batcheller. “Nurses, especially experienced nurses, want to feel valued. When they have more time to care for patients, there’s a different environment on the units.”

In a December nursing satisfaction survey, 77 percent of respondents said they “feel a

*continued on page 8* →

## “Nurses, especially experienced nurses, want to feel valued. When they have more time to care for patients, there’s a different environment on the units.”

sense of accomplishment and pride after completing work on the unit.” In other words, Seton believes it is building the kind of place where nurses want to stay.

### Less Time on Errands

Nurses and other employees at Seton benefit from a free, on-site concierge service that helps them handle many of the personal tasks they would have to do in their free time. This includes errands like going to the post office, getting an oil change, and picking up dry cleaning.

The time saved by nurses can add up: Seton staff estimate that the concierge service could save as much as 16 hours a month—or about 13 weekends a year. That way nurses can truly enjoy their free time.

“We want nurses to feel less stress because someone else has taken care of their errands while they work,” said Batcheller. The hospital won’t disclose the cost of the program, which is too new to provide any hard ROI data. “The real intent is to help our staff with personal errands while at work as part of our ongoing commitment to work life.”

Other highlights: Seton offers a seasonal 80-hour reward that encourages nurses to work 80 hours per pay period during the hospitals’ busiest times. They also offer a seasonal flex plan for experienced critical care nurses, which allows them to take up to three months off during the summer. ☘

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Joyce Batcheller, RN, MSN, CNAA, is network CNO at Seton Healthcare Network in Texas and is a Robert Wood Johnson executive nurse fellow (jbatcheller@seton.org).

## Best Practices for Retaining Older Nurses

In *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace*, the Robert Wood Johnson Foundation outlines 12 best practices that contribute to older nurse retention. Here is a brief summary:

**Increasing 401(k) participation and redefining pensions.** Hospitals should help employees capitalize on the benefits of employer-provided retirement plans.

**Caregiving and grief resources.** Organizations should help nurses balance their caregiving responsibilities and personal challenges while remaining employed.

**Corporate cultures that value mature workers.** The best hospitals for older nurses view employees as a “resource to be cherished rather than a liability to be minimized.”

**Flexible work options.** This includes options such as job sharing, part-time work, and compressed work schedules.

**Planning for retirement.** Nurses are often unprepared for retirement, and hospitals should offer retirement planning programs to their staff.

**Phased retirement.** Many hospitals offer older workers an option to leave the workforce gradually by reducing the number of hours worked before full retirement while continuing to accrue benefits.

**Knowledge transfer paired with phased retirement.** In this practice, the soon-to- retire nurse trains a replacement within a flexible schedule, so the new hire gains from the knowledge and skills of the experienced nurse.

**Magnet status.** Although not specifically designed to address the older nurse, Magnet status may be important to retention. Studies indicate that RNs have higher rates of job satisfaction when they work in Magnet hospitals.

**Mentoring programs.** Hospitals should provide formal or informal ways for older nurses to share their knowledge with less experienced nurses.

**Talent management.** Organizations should conduct a workforce analysis to gain a greater understanding of factors such as age, career level, and skill sets.

**Professional development.** Hospitals should offer training and career enhancement programs geared toward older nurses.

**Workplace and ergonomic improvements.** Older nurses may leave a hospital because of poor physical working conditions. Hospitals that make working environments safer, more comfortable, and more productive are likely to attract and retain older employees.

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**Compare Physicians Within each**

**Service Line**

“Doctors can either sink the service line or make it profitable,” Cone said. “You really need to take a look at the resources that they’re using.”

At Sharp Grossmont, the physician with the third highest number of cardiac procedures only brought in an estimated \$28,000 in profit in 2006. In comparison, the most profitable physician, who handles fewer cases, brought in nearly \$390,000 (see the exhibit on page 2).

There may be a variety of reasons for physician differences, as simple as a physician’s payer mix, Cornicelli said. But other possibilities must be investigated, including the use of expensive stents and implantables, long lengths of stay, or high complication rates.

When the data at Sharp Grossmont showed that some physicians had higher complication rates than their peers, the hospital’s Cardiac Steering Committee took action.

A holding area for post-cath procedure patients was established because committee members suspected that the complications were related to sheath-removal techniques.

**Repeat the Analysis for Outpatient Procedures**

It can be worthwhile to compare volumes and profitability for outpatient procedure codes to inpatient procedure codes (see exhibit on this page).

Some payers, including Medicare, reimburse at much higher rates for inpatient services than outpatient services, even when (for example, for cardiac cath) a hospital may have the same costs and use the same physical space, staff, and protocol for inpatients and outpatients alike. For example, Sharp Grossmont is reimbursed \$9,659 for one type of vascular procedure if it is coded as an inpatient case, but just \$7,588 if the outpatient rate applies.

Of course, coding is strictly regulated, but this analysis may highlight opportunities

**Use diagnostic-related group codes to organize inpatient cases into groups for analysis. For example, cardiac cases could be separated into the service line’s four major components: medical cardiology, electrophysiology, cardiac surgery, and interventional cardiology.**

where more accurate and complete documentation could justify higher reimbursement. Or it may identify the need for new protocols that save the hospital money.

For example, Sharp Grossmont generated savings when it established an outpatient observation area for patients presenting with angina and certain acuity levels of congestive heart failure. Instead of admitting the patients to the hospital, as would have been done previously, Sharp Grossmont now provides care for them as outpatients with the goal of having patients ready to go home in less than 24 hours.

**Dig Deeper Into the Data**

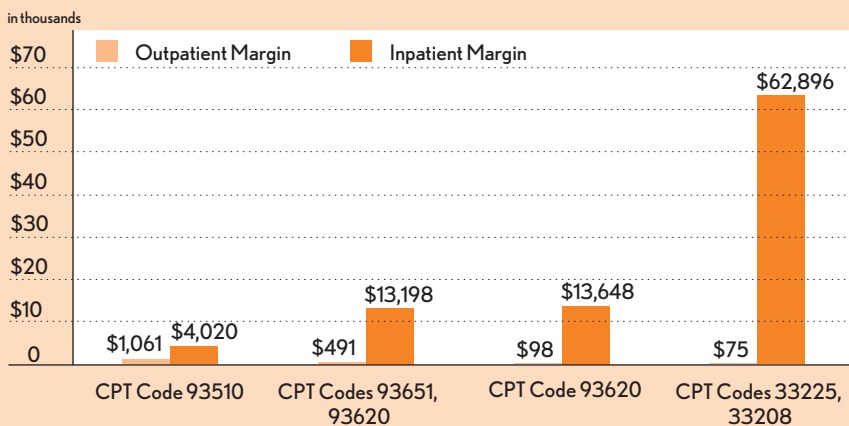
You may find that looking at the data only turns up more questions. “Together you [and your nurse executive] can analyze the reports from a strategic perspective and decide next steps,” Cornicelli said. “It might be that you work with certain physicians on certain issues. It might be a decision to purchase additional equipment.”

Often this means digging up more data to analyze. “If you haven’t drilled the data, you don’t know what you don’t know,” Cornicelli said.

For more information, contact Maryann Cone, RN, MS, CNAA, BC, CNO and vice president of patient care services at Sharp Grossmont Hospital in San Diego (maryann.cone@sharp.com). You can also contact Kari Cornicelli, CPA, FHFMA, CFO and vice president at Sharp Grossmont (kari.cornicelli@sharp.com).

**Evaluate Inpatient vs. Outpatient Margins**

Sharp Grossmont Hospital Interventional Cardiology Procedures  
Outpatient vs. Inpatient Contribution Margins\*



\* The CPT coding system for outpatient procedures is more complicated than the inpatient DRG system. Several CPT codes often have to be grouped together to equate to one DRG.

Source: Sharp Grossmont Hospital in San Diego, ©2007. Reprinted with permission.

Hospitals are often paid varying amounts by payers for outpatient and inpatient services. In some cases, the services provided and the associated costs are similar. After looking closely at outpatient versus inpatient margins, hospital staff can begin to explore ways to get more money from payers—without harming patient care. For example, could some inpatients be safely cared for as outpatients? Do clinicians need to do a better job of documenting certain procedures to justify a higher reimbursement?

# Where Does the Money Go? Budgeting Scenarios for Front-Line Clinicians

**Here's an idea: Try teaching staff nurses about the intricacies of budgeting—before they become managers. That's what nursing leaders at University Health Care at the University of Utah are doing. And the staff nurses love it. Besides building future managers, the budget training gives clinicians a real-life taste for the day-to-day challenges that hospital leaders face in trying to fund quality patient care.**

At University Health Care, the nursing council (a shared governance team) has a commitment to education along with its usual committee work. As part of its leadership training, council members decided they would like to learn more about budgeting.

“Budgeting isn't something you learn about in nursing school,” says Kathy Schmitz, MAOM, RN, service director of the women's and children's service line for the Salt Lake City organization. “Then, as a staff nurse, you never get exposed to the details

of the budget. You just hear, ‘No, we can't do that, because it doesn't fit into the budget.’ We thought this would be a great way for nurses to learn more about their leaders' roles and responsibilities.”

Schmitz developed “Budgeting 101,” a seminar designed to give nurses the basics on how budgets are developed and implemented. The seminar covers topics such as how to identify positive and negative variances and how to calculate workload units. (Visit [www.hfma.org/boc](http://www.hfma.org/boc) to see Schmitz's Powerpoint® presentation.)

At the end of her presentation, Schmitz separated the participants into groups. She provided each group with the following:

- > A simplified version of a hospital's operating statement—see the spreadsheet on page 11
- > A real-world budgeting problem to solve—see “Sample Budget Scenarios” on this page

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## Sample Budget Scenarios

**Use the sample hospital operating statement (on page 11) to solve the following challenges:**

### Scenario 1

You are a manager of a large med/surg unit and have just learned that a new physician has come on board. This physician will add five new patients per month with an average length of stay of 5.6 days. You are already experiencing overruns in your salary costs. You know that you have to bring the budget in on target.

**Your challenge:** Accept the increased census and meet the budgeted contribution margin.

**Potential solution:** Because the contribution margin is a reflection of both income and expenses, you can calculate the expected rise in revenue from the added patient days as: 5 patients per month at 5.6 LOS = 28 more days of

revenue. If you do not add any more staffing hours, you will more than meet the expected budgeted contribution margin. If you can reduce overtime and agency nurses, you will do even better.

### Scenario 2

You are a manager of a specialty unit and have just learned that four of your full-time staff are resigning because their spouses have new jobs out of state. There are no nurses in the application pool and there haven't been for three months.

You are already experiencing some short staffing on certain shifts, and you know you are about to go into your busiest time of the year. You need six nurses on days; five on nights. You are down to five on days and four on nights. You are under budget in salaries for the month but slightly over for the year to date. Your average RN salary is \$23.00 an hour.

**Your challenge:** Staff your unit without going over your salary budget.

**Potential solution:** You are under in your RN and aide salary costs, but over in overtime and contract nursing dollars. Shift costs away from overtime and contract agency by going with more per diem hours and travel nurse assignments, and by using more support staff.

Though they may be more expensive than full-time RNs, per diem staff will be—in general—less expensive than overtime and agency staff. Next, consider hiring travel nurses, which is a better option than agency nurses as they add stability to the schedule. Also, you have the opportunity to hire travel nurses at the end of their assignments. In addition, if you have a nurse educator and/or an assistant head nurse, move that person into some additional clinical hours.

## A Simplified Hospital Operating Statement

Staff nurses can use this simplified version of a hospital's operating statement to work out the budgeting scenarios presented on page 10.

October 31, 2006

ACCOUNT	DESCRIPTION	YEAR TO DATE			TOTAL BUDGET
		ACTUAL	BUDGET	VARIANCE	
	IP: SERVICES REVENUE	10,253,110.00	9,920,328.00	332,782.00	29,460,984.00
	IP: ANCILLARY REVENUE	131,702.35	174,660.00	(42,957.65)	52,390.00
	ESTIMATED CONTRACTUAL ADJ	(4,444,699.68)	(4,340,844.00)	(103,855.68)	(13,022,532.00)
		-	-	-	-
	<b>TOTAL NET REVENUE</b>	<b>5,940,112.67</b>	<b>5,754,144.00</b>	<b>185,968.67</b>	<b>16,490,842.00</b>
<b>CONTROLLABLE EXPENSES</b>					
	REGISTERED NURSES	1,380,733.12	1,436,732.00	55,998.88	4,310,196.00
	LICENSED PRACTICAL NURSES	797.96	-	(797.96)	
	CLINICAL AIDES	36,901.81	44,288.00	7,386.19	132,864.00
	CLERICAL/OTHER ADMINISTRATIVE	52,285.78	60,248.00	7,962.22	180,744.00
	SHIFT DIFFERENTIAL	157,488.02	159,136.00	1,647.98	477,408.00
	OVERTIME REGULAR	226,309.65	151,388.00	(74,921.65)	454,164.00
	OUTSIDE CONTRACT NURSING	31,445.00	-	(31,445.00)	-
	<b>TOTAL SALARIES AND WAGES</b>	<b>1,885,961.34</b>	<b>1,851,792.00</b>	<b>(34,169.34)</b>	<b>5,555,376.00</b>
	SUPPLIES: OFFICE	763.97	1,200.00	436.03	3,600.00
	SUPPLIES: GALLEY/PATIENT FOOD	6,593.69	6,395.00	(198.69)	19,185.00
	SUPPLIES: PATIENT EDUCATION	323.00	812.00	489.00	2,363.00
	MEDICAL/SURGICAL SUPPLIES	105,443.84	87,996.00	(17,447.84)	255,970.00
	INFECTION CONTROL SUPPLIES	117.12	340.00	222.88	984.00
	PERSONAL PROTECTIVE ATTIRE	7,426.37	6,860.00	(566.37)	19,954.00
	SUTURES	338.43	44.00	(294.43)	126.00
	IMPLANTS: OTOLARYNGOLOGY	278.89	72.00	(206.89)	213.00
	IMPLANTS: CARDIAC/VASCULAR	-	20.00	20.00	62.00
	SYRINGES AND NEEDLES	19,148.53	17,664.00	(1,484.53)	51,386.00
	OXYGEN/GASES	23,212.00	22,080.00	(1,132.00)	66,240.00
	MEDICINE	72,880.00	65,749.00	(7,131.00)	197,247.00
	COMP/DATA: SUPPLIES	1,311.83	852.00	(459.83)	2,559.00
	PRINT/COPY: PRINTED FORMS	4,685.22	4,124.00	(561.22)	12,000.00
	PRINT/COPY: PHOTOCOPYING	(554.70)	(284.00)	270.70	(825.00)
	TELCOM – MONTHLY RECUR CHARGES	3,355.64	3,356.00	0.36	10,067.00
	TELCOM – TOLL CHARGES	179.35	232.00	52.65	692.00
	TELCOM – MISCELLANEOUS	1,834.56	1,836.00	1.44	5,504.00
	TELEPHONE: PAGERS	(30.50)	260.00	290.50	780.00
	POSTAGE	69.88	96.00	26.12	283.00
	REPAIR/MAINT: EQUIPMENT	3,446.91	5,740.00	2,293.09	17,221.00
	RENT: EQUIPMENT	2,560.00	8,384.00	5,824.00	25,158.00
	RENT: COPY MACHINE LEASE/PURCH	1,486.00	1,372.00	(114.00)	4,112.00
	FREIGHT	977.27	944.00	(33.27)	2,832.00
	<b>TOTAL SUPPLIES, SERVICES</b>	<b>255,847.30</b>	<b>236,144.00</b>	<b>(19,703.30)</b>	<b>697,713.00</b>
	<b>TOTAL CONTROLLABLE EXPENSES</b>	<b>2,141,808.64</b>	<b>2,087,936.00</b>	<b>(53,872.64)</b>	<b>6,253,089.00</b>
	<b>CONTRIBUTION MARGIN</b>	<b>3,798,304.03</b>	<b>3,666,208.00</b>	<b>(132,096.03)</b>	<b>10,237,753.00</b>
	<b>STAT – PATIENT DAYS</b>	<b>5,480.00</b>	<b>5,534.00</b>	<b>(54.00)</b>	<b>16,602.00</b>

Source: University Health Care at the University of Utah, Salt Lake City ©2007. Reprinted with permission.

# Financial Outlook: Not-for-Profit Hospitals

*Many people may assume that not-for-profit hospitals are not very good at making a profit. They may also assume that for-profit hospitals are likely to be rolling in dollars to invest. But the business outlook picture is no longer cut and dry. Recent financial reports suggest that not-for-profit hospitals are giving for-profits a run for their money.*

## Not-for-Profit vs. For-Profit: What's the Difference?

In a nutshell, not-for-profit hospitals receive tax breaks in exchange for providing services—such as charity care—that benefit the community. They are supposed to reinvest their profits back into the hospital, with the ideal goal of enhancing community services. In addition, not-for-profit hospitals are accountable to the public, through a board of directors that represents the healthcare needs of the community. In contrast, for-profit hospitals are ultimately responsible to stockholders.

In general, not-for-profit hospitals get three types of tax breaks:

- > They don't pay capital taxes on income and property.
- > They don't pay taxes on bond financing, and their endowments may earn tax-free income.
- > They can deduct charitable contributions.

## Not-for-Profits Are Facing Increased Scrutiny

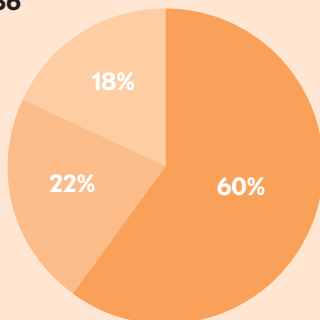
The tax-exempt status of many not-for-profit healthcare organizations is under increasing scrutiny by local, state, and federal governments. Over the past several years, lawsuits have been filed against many not-for-profit hospitals, alleging that aggressive billing and collection practices violate the hospital's tax-exempt status.

In 2004, the Internal Revenue Service unveiled an enforcement program that scrutinizes not-for-profit organizations that violate tax laws. The IRS is also trying to stop tax-exempt organizations from overpaying their executives. In 2007, the IRS will specifically examine how hospitals determine compensation for their executives.

As a result of these developments, many not-for-profit hospitals are trying to be more open about reporting the charity care and other community benefits that they provide. The Catholic Health Association released guidelines for community benefit reporting, which have been heralded by many, including HFMA.

## The Majority of Community Hospitals Are Not-for-Profit

Total number of U.S. community hospitals:  
**4,936**

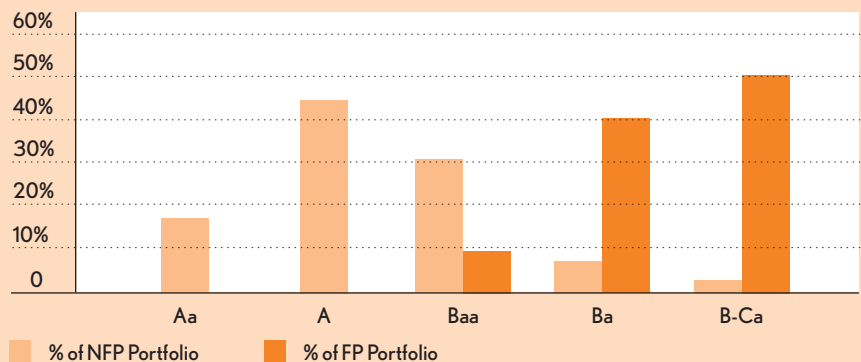


- Non-governmental, not-for-profit: **2,958 (60%)**
- State and local government hospitals: **1,110 (22%)**
- Investor-owned for-profit hospitals: **868 (18%)**

Source: AHA 2007 Hospital Statistics

## Not-for-Profit and For-Profit Hospital Rating Distributions Vary Significantly\*

Only 10 percent of the not-for-profit hospitals were rated below investment grade by Moody's Investors Service. (See page 13 for an explanation of bond ratings.) In comparison, most of the for-profit hospitals were rated below investment grade. Moody's cites several reasons for the weakened financial picture at for-profit hospitals, including ongoing federal investigations, senior management turnover, the proposed buyout of HCA, and increases in bad debt and charity care.



\* Moody's currently maintains ratings on 10 for-profit hospital companies representing about 470 hospitals and 543 not-for-profit hospitals and health systems, representing about 1,200 hospitals.

Source: *A Look Inside For-Profit Hospital Companies: Less of a Threat to Not-for-Profit Hospitals Today than in the Past. Not-for-Profits Strengthen as For-Profits Regroup.* Moody's Investors Service, October 2006. Reprinted with permission.

# Nurses Benefit from Documentation Systems, Too

Computerized documentation systems help ensure that hospitals get paid for everything that nurses and other caregivers do every day.

We just got a new computerized documentation system. Even though nurses do all the work to input the information, it seems like the system just benefits the financial people by giving them more billing and coding data. What's in it for nursing?

When hospitals implement new systems, it can seem to clinical front-line staff that they have to do a lot of extra work just to gather more billing and coding information. However, more detailed charting allows for better patient care by giving a more complete picture of a patient's condition.

There is also a potential future benefit to nursing. Payers do not currently reimburse hospitals for most of the day-to-day care that nurses provide; however, AONE and other groups are working to change that. In the meantime, the best way we can demonstrate the financial worth of nursing care is to provide these detailed records, so that payers can begin to attach monetary values to it.

When the hospital actually receives all of the revenue that its caregivers have earned, this en-

ures that the organization has the funds to continue providing high-quality care. These systems also help the hospital gather data on care quality and efficiency, to assist in quality improvement efforts. ☎

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Kathleen D. Sanford, RN, MA, DBA, FACHE, is past president of the board of directors of the American Organization of Nurse Executives and senior vice president and CNO of Catholic Health Initiatives. Do you have a question for Kathleen? Email her at [kathya-one06@yahoo.com](mailto:kathya-one06@yahoo.com).

## Finance-to-Nurse Interpreter

**Bonds:** Bonds are a key source of long-term financing that hospitals use to fund major capital improvements, such as equipment purchases and building projects. Bonds are a form of debt issued for a period of more than one year. In other words, a bond is a long-term loan or IOU.

The bond buyer (for example, a bank) lends the money. The bond seller or "issuer" (that is, the borrowing healthcare organization) typically agrees to pay interest periodically, usually every six months. The healthcare organization must also pay the principal, or face value, of the bond/loan on a specified maturity date.

There are several different types of bonds; two commonly issued types are:

> **General obligation bonds**, which are secured based on the taxing and borrowing power of a city or other municipality. In healthcare financing, GO bonds may be issued or underwritten by a city or other municipality. But they must be repaid by the healthcare institution. Depending on the terms of the bond indenture (loan document), the municipality serves as the co-signer.

> **Revenue bonds**, which are repaid by the revenue from the particular project, such as a new ambulatory surgery center or bed tower addition that was built with the borrowed money. Revenue bonds are secured not only by the revenues directly earned by the project being financed, but may also be secured by all of the general revenues of the facility.

**Bond Rating:** A healthcare organization receives a bond rating from an agency that assesses that organization's creditworthiness, or ability to repay the loan. Standard & Poor's, Fitch Rating Agency, and Moody's Investors Services are well-known rating agencies.

Bond ratings help investors decide whether they want to buy a bond from the issuing organization. The rating system is based on symbols; typically, AAA is the highest rating (meaning the bond is a low-risk investment) and D is the lowest (meaning the bond is high risk). The higher the bond rating, the lower the interest paid by the issuing institution.

A hospital's bond rating might depend on many factors, including its ability to control costs, use

**The rating system is based on symbols; typically, AAA is the highest rating (meaning the bond is a low-risk investment) and D is the lowest (meaning the bond is high risk).**

resources efficiently, manage its balance sheet, and maintain a strong presence in the local market. In recent years, bond rating agencies have placed increased emphasis on a facility's ability to recruit and retain nursing and other healthcare professionals, quality control issues, incidence of professional liability claims, and the facility's ability to strategically plan for the future. Nurse managers play a key role in these areas of increased scrutiny.

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Donna Gellatly, MBA, FHMFA, CPA, professor emeritus in the Health Administration Program at Governors State University, lent her expertise in defining these terms ([DLG2727@aol.com](mailto:DLG2727@aol.com)).

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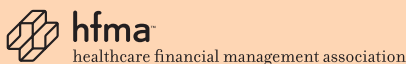
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The American Organization of Nurse Executives

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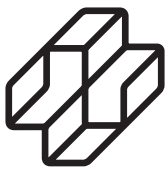
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See page 14 for  
Career Opportunities



The American Organization of Nurse Executives

AONE is comprised of approximately 5000 nursing professionals whose titles include: ♦ Chief executive officer ♦ Chief operating officer ♦ Chief nursing officer ♦ Vice president of patient care services ♦ Director of nursing ♦ Nurse manager ♦ Staff nurse ♦ Nurse consultant ♦ Nurses who hold management/leadership positions in vendor organizations

AONE provides its members with Educational and Career Enhancement Opportunities.

AONE holds annual meetings such as the 40<sup>th</sup> Anniversary Celebration: *Live the Legacy: Power, Politics and Persuasion*, to be held in Washington DC, April 12-16, 2007.

AONE offers its members publications such as *Voice of Nursing Leadership*, *Nurse Leader* and *e-News Update*.

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